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MEDICOLEGAL AND PATHOLOGICAL ASPECTS OF SUICIDE*

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MOST PEOPLE think of murder when they hear the coroner or medical examiner mentioned. Perhaps this is the case because most medicolegal law was originally set up to detect unrecognized murder and document for court the obvious homicides.

The present day forensic pathologist, however, has many other responsibilities in a progressive community.[2] He not only documents homicide but also guards the public interest by removing unwarranted suspicion arising over a given death and assists law enforcement officers by acting as an impartial arbiter in investigating sudden and apparently unexplainable deaths.

To the average physician suicide represents no problem after it has taken place. Many may wonder what the medicolegal aspects of suicide are.

Suicide is a challenge to the forensic pathologist for a number of reasons. Unlike the family physician or the psychiatrist he is often denied a correct history by the family. Most of the suicides that I am called to investigate are in individuals who were making a good living, happy in their work and with their family, and planning many activities for the next day.

Table I shows the number of suicides in Massachusetts in 1949 compared with deaths from other rather common causes to show the problem as it exists.

TABLE I

(Modified from the Annual Report, Division of Vital Statistics, Commonwealth of Massachusetts, 1949)

Total Deaths 51,101

Cause of Death	*Number*	*%*
Carcinoma of rectum	536	1.05
Suicide	517	1.01
Motor vehicle accidents	451	0.89

*Presented before the Providence Medical Association, at the R. I. Medical Society Library, Monday, April 6, 1953.

I am sure many feel it makes little difference what a suicide is called after the fact. In some cases this may be so but it is also true that many times if a proper suicide verdict is not reached, other persons will be brought into the picture unjustly.

To enlarge a bit—it is natural for a family to attempt to obscure a suicide because of the stigma attached. Whether or not this is as it should be, at the present this is the attitude of society and we must work with it.

The most benign form of concealment is attempting to make death by suicide appear to be from natural causes. This ranges from cutting down a hanging body and placing it neatly in bed to arguing that a man found in the river had a heart attack and fell into the water.

A second form of concealment is to claim that a suicide is an accident. Such cases pass from interest in the family name to interest in the family pocketbook. Since a number of suicides are related in some way to the place of employment, industrial compensation is involved if the death is ruled accidental. Many insurance policies contain double indemnity accident clauses so an *"accidental suicide"* can well involve civil litigation.

The argument might be advanced that a widow could use double the amount of her late suicidal husband's insurance policy, but this is fallacious reasoning. Awards made by insurance companies directly regulate the premiums. It may be true that a few additional accidents raising insurance costs are spread over so many policy owners that the cost to each is minimal; however, more important is the fact that insurance companies then write clauses in their policies which directly penalize the innocent. A good example of this is an accident policy that I saw which excludes all deaths by carbon monoxide, whatever the manner. In other words, the man who dies in his car because of a defective muffler or exhaust pipe or the parents who meet death because of a defective furnace, hot water heater, or gas refrigerator cannot be insured against these legitimate accidents under such a policy because too many gas suicides have been ruled accidental.

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A third method of concealing suicides in an attempt to protect the family name, which is downright criminal, is accusing some innocent person of murder. This is the least-common method employed but it has and does occur. The following case illustrates the point.

LM#52-64. A 35-year-old white man was found on his bed dead of a gunshot wound of the chest. He had been in the process of divorcing his wife and was in financial difficulty. He was found by a girl friend. No weapon was in evidence. The dead man's father and a hired man offered the opinion that he was murdered and accused the girl friend. The gunshot wound was located in the left chest and the gun had been two to three inches from the body when fired. There was no gross evidence of powder or grease on the decedent's right hand.

Because the financial difficulty suggested a motive and the wound was similar to those frequently found in suicides, the father was interrogated. After several hours, he admitted that he had found the body and removed the gun from the bed, later hiding it in a shed behind the building.

In some states it is a violation of mental hygiene laws to commit suicide. Therefore, to conceal or attempt to conceal a suicide is a violation of the law.

The forensic pathologist, when he investigates a death which may or may not be a suicide, has three types of evidence which he may use. First, the history obtained from the police or family physician; second, the findings on the body and third, the evidence collected at the scene.

In some cases he is able, by the results of his autopsy and toxicological studies, to determine the cause and manner of death. Other times he can determine only the cause of the death and the manner will depend solely on history and police investigation. The latter is true when a fully clothed uninjured man is found drowned. Here the cause of death may be established as drowning by autopsy and chemical analysis of the chloride content of the chambers of the heart. How and why he got in the water can only be established by witnesses of the act or by inference from a history of despondency.

A pathologist, by examination of the body, can establish that a distant gunshot wound of the back is incompatible with suicide, or he may be able to establish that a contact gunshot wound of the temple was self inflicted because the powder residue on the decedent's fingers matches the outline of the weapon found at his side.[5, 7]

Table II shows the types of suicides which are encountered.

TABLE II
(Modified from the Annual Report, Division of Vital Statistics, Commonwealth of Massachusetts, 1949)

Total Deaths		**51,101**	
Suicides		**517**	
Suicide By		*Number*	*%*
Carbon monoxide		129	24.9
a) Domestic gas	111		
b) Motor vehicle exhaust	18		
Hanging and strangulation		126	24.3
Firearms		103	19.9
Drowning		45	8.8
Barbiturate intoxication		34	6.5
Cutting and stabbing		19	3.6
Jump from height		18	3.4
All other		43	8.6

In cases investigated by our department, only 40% of suicides leave a note and many are so unintelligible that they offer evidence only that the victim's mind was confused. Many are written under the influence of alcohol and are illegible as well as unintelligible. In 3 to 4% of the suicides with no notes, it is later learned that there had been notes which were destroyed or removed by the family.

Another important bit of history for the forensic pathologist is a previous attempt at suicide. Many have been in hospitals for an *"overdose"* of barbiturates. It is difficult to say how many suicides have made previous attempts. Unusual scars on the wrist or neck bear mute evidence of a previous unsuccessful attempt.

When a "motive" or questionable history is obtained, the most important procedure in the investigation is the medicolegal autopsy. Naturally these cases must be studied from many angles. For example, a death which appears due to natural cause, from history and external examination, may be barbiturate intoxication, cyanide poisoning or nicotine ingestion. On the other hand, a gunshot wound or cutting is often obvious to the person discovering the death.

Poisoning must be considered in relation to dose ingested.[4] Accidental overdose of barbiturates is very uncommon. If the equivalent of 15 to 20 pentobarbital capsules is recovered from the stomach, it is very unlikely that they were taken accidentally—only rarely are capsules of any drug taken therapeutically in such numbers.

Barbiturate intoxication is sometimes disclosed at autopsy by congestion and erosion of the gastric mucosa (Na salts) together with bronchopneumonia in a person with no debilitating disease or injury. The bronchopneumonia is secondary to coma. As a primary disease, it is uncommon in young or middle-aged adults. Occasionally, portions of the capsules or their content can be found in the stomach contents. The diagnosis is confirmed by toxicological analysis of blood and stomach contents.

When one is familiar with the various methods of suicide by poison, he considers compounds associated with the occupation or hobbies of the decedent. A case in point is the following.

LM#52-104. A 46-year-old man died suddenly early one morning in the kitchen of his home. His wife reported that he got up to get a drink of water. A few minutes later she heard him fall and found him "frothing" at the mouth. There was no history of coronary disease or chest pain and the medical examiner, unable to sign the certificate with any degree of accuracy, ordered an autopsy. The pathologist found the typical pyknic build associated with coronary disease but a normal heart. The gastric contents were watery and brown and the mucosa had a tan color, suggesting nicotine poisoning. Chickens were raised in the neighborhood. Nicotine sulphate (40%) also marketed as "Black Leaf 40" is used to delouse poultry. The decedent had 2.3 gms. of nicotine in his stomach contents and 1.2 mg. % in his blood. Later, history revealed that he had been a mental patient. No other history was available.

Cyanide suicides are rare in the general population but are common in people who work with it—namely, jewelry workers and photographers.

The location and nature of the wound are important in gunshot deaths. Most suicidal gunshot wounds are located in the right temple, the forehead usually to the right, and on the left side of the chest coming from the right (in right-handed people[6]). Such wounds are usually contact in type, containing powder residue under the surface and the edges are abraded from the muzzle of the gun.[1]

Hesitation marks in cuttings are significant and are almost always associated with suicidal injury.[9] There may be several superficial incisions and even the fatal wound may be shallow.

Frequently multiple methods of suicide are used or attempted. In a case of minor gunshot injury, chemical analysis may disclose barbiturates in the stomach and blood. Small superficial incisions may be found in the skin of the wrists or neck in a carbon monoxide death which could otherwise appear accidental. The following case will illustrate multiple methods.

LM#51-154. A 34-year-old white married woman was known to have been drinking. She had locked her husband out of their hotel room. Her husband attempted to enter the room and she replied only in "mumbles." Later he again attempted to get in and when he got no reply, he called the police. When they entered the room, they found her dead on the floor with a cut neck. She had lost only 50 ml. of blood. On the dresser was a glass half-filled with a turbid white liquid and a razor blade.

The wounds of the neck were superficial barely penetrating the dermis. The gastric contents were not remarkable. The mucosa of the stomach was not burned. Toxicological analyses on the blood showed it to contain 0.34% ethyl alcohol and 1.4 mg. % of barbiturate. The material in the glass was phenobarbital.

A note addressed to her husband was illegible. The levels of alcohol and barbiturate were both sub-lethal but their synergistic action was sufficient to cause death.[3]

Often pathology is helpful in explaining apparent discrepancies at the scene of a death, such as gunshot wounds where death was not instantaneous. The following case illustrates the value of microscopic examination of tissues in a medicolegal case.

LM#52-29. A 19-year-old male was found shot in the right temple. The room where he was discovered was covered with blood, furniture was tipped over and papers were strewn about the floor. Autopsy showed that the bullet passed only through bone in the flight through the head. There were multiple skull fractures, particularly comminution of the roof of the orbit, and both optic nerves were severed. Death resulted from a subdural hematoma and contusions to the under surfaces of the frontal lobes. The lungs showed an early bronchopneumonia. On microscopic examination of the entrance wound, there was early inflammation in the dermis and temporal muscle. The injuries would have allowed him to move about the room for some time, although blinded. He had lived 4 to 6 hours after the injury.

No two suicides are exactly alike. No hard and fast rules can be established to cover all cases completely. It is only by careful investigation and complete pathologic and toxicologic examination that a death can be fully clarified.[8] This paper is a brief report of some of the problems concerning suicide which the forensic pathologist and the community face in this present day.

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SOME CLINICAL ASPECTS OF SUICIDE*

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ALTHOUGH suicide is a major cause of death, we are surprisingly ignorant of many factors pertinent to its understanding. Bearing in mind that statistics have definite limitations in the study of suicide, we must nevertheless examine them and see what trends they reveal. Statistics record only those suicides where the evidence is unquestioned. There are, of course, many serious suicidal attempts which are the result of strong suicidal impulses which do not terminate fatally. If they do terminate fatally, death may result from an intercurrent cause and the factor of suicide is frequently entirely disregarded as far as the cause of death is concerned. Social prejudice, inadequate information, and disguised suicides further weight the statistics against suicide as a cause of death. This does not take into consideration the so-called "unconscious" suicidal drives which cause people under certain circumstances to take unusual chances with their lives or slowly but nonetheless surely destroy themselves by alcohol, drugs, or other influences harmful to their well-being. I think it is evident that statistics at best do not give an accurate picture of the prevalence of suicidal drives which are present in the general population, and that their prevalence is much more common than is generally appreciated.

There are, however, a number of interesting factors that statistics concerning suicide point out. There were in the United States 11.2 deaths per 100,000 population in 1947. More men commit suicide than do women, although women attempt it more frequently. American negroes commit suicide comparatively infrequently. The older the person, the more likelihood there is of his committing suicide. In men, firearms and hanging are by far the most frequently employed methods, while in women poisons and gas are by far the most frequently employed. The suicidal rate is greater in urban areas than in rural areas. There are fewer suicides among Catholics than among Protestants, especially in areas where the Catholic religion predominates. Suicidal rates increase during times of social and cultural change; for example, in Europe following the last war, especially in Germany.

There are several interesting trends that statistics reveal which deserve special attention. In the first place, the suicidal rate seems consistently lowered during times of war and rises following the war. This was true following World Wars I and II. Some statistical studies have recently been published concerning Finland and Western Germany which indicate that the suicidal rates have increased considerably since the close of the war. In Western Germany the highest rate occurred in 1945, the year the war ended in Europe. In the second place, statistical studies reveal that in any given area, the suicidal rate varies inversely with the homicidal rate.

Statistics, of course, tell us nothing about the individual who attempts or commits suicide, and we must turn to clinical studies of the individual's psychology for a clearer understanding. It is like changing from field glasses to the high power microscope. With the former, we scan the overall picture of society, while with the latter, we scrutinize the components of the individual, especially in regard to his psychology. Both are important. The former, however, involves sociological, philosophical, moral, and ethical issues. For example, looking at the statistics the question might come up whether periodic wars are necessary to keep individuals from destroying themselves; or whether the suppression of aggressive impulses by existing mores is too great; or whether our civilization has become too complex and too demanding. As physicians, we cannot divorce ourselves from these issues entirely, but we must continue to expend our primary energies to the treatment of illnesses. As physicians, we are especially interested therefore in the person who as the result of mental illness is in danger of taking his own life. It should be emphasized at this point that all suicide does not seem to be the result of mental illness. We have all known of people who with apparent clarity of mind and feeling have taken their own lives for a variety of reasons. For example, a well-known business man who seemed well all of his lifetime both physically and mentally, learned that he had an incurable illness at an old age. One evening after what seemed

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to be a usual day, he shot himself. He left a note saying that he was incurably ill and that he knew he would die. He said he saw no reason why he should wait. He apparently chose to take into his own hands the time and method of his death.

The act of suicide as such cannot be used to make a diagnosis of a mental illness but should be looked upon when it occurs as possibly one symptom among others of a mental illness. It is important to emphasize, however, that in all suicides the same forces seem to operate. The difference being the degree to which these forces are under the control of conscious motivation or the degree to which the person is attached to life. The forces which are in operation, to which statistics as well as the study of the psychology of the individual lend strong support, are the aggressive ones. The aggressive forces are one of the sources which provide the basic energy for all of the individual's thoughts, feelings, and actions. The energy thus provided is ordinarily sublimated and channeled into activities which are wholesome to the individual and society. When the integration of aggressive forces is broken down, suicide or homicide may be the result. In suicide the aggressive forces are turned on the individual himself to the point of self-destruction, while in homicide they are turned on someone else. In this regard, there is a reciprocal relationship between suicide and homicide.

Almost everyone at one time or another has thought of suicide, and the drive reaches so-called pathologic proportions in the whole gamut of psychiatric illnesses as well as under certain conditions when no psychiatric illness is apparent. Why they reach pathologic proportions in any given individual is not fully comprehended. It certainly does not seem correct to refer to them as inherited characteristics, although suicides follow family patterns at times. In these circumstances, they are usually more correctly interpreted as occurring in pathologic proportions through the process of identification with an important person in the patient's life who committed suicide during certain formative years of the patient's development, usually somewhere between the ages of 6 and 14. When individual cases are examined, one is less impressed with external circumstances acting as causes than with the way the individual reacts toward these circumstances. It is surprising at times to find the suicidal rate lower under conditions which might be expected to produce many suicides. This is pointed out statistically by the fact that the suicidal rate is consistently lower during times of economic depression. Even in the cases in which the person discovers that he has an incurable illness and takes his life apparently because of it, it must be something within the individual that makes him react in that way. Such an act can be viewed as a very aggressive one, a defiance of the laws of life. Apparently some people can tolerate great amounts of external pressure while others can tolerate but little.

As is all too frequently thought, suicide is by no means limited to people who are depressed. It is true, however, that depressed people present the biggest problem, numerically speaking, in regard to suicide. The depressed patient is unable to express aggression externally by direct means but turns it on himself. This does not mean that he has no aggressive impulses within him, but he feels guilty for having them and cannot express them outwardly. Psychotically depressed people feel so strongly about it at times that they destroy themselves in what they feel is justified self-punishment. They are usually retarded, self-accusatory, have feelings of hopelessness and despair, and do not sleep or eat well. The most dangerous time for these people as far as suicide is concerned is frequently when they seem to be getting better and are becoming more active. During the severest portion of the depression they may be too retarded to carry their feelings into action. Denial of suicidal intent in these patients should not be taken at its face value and may be strong evidence that they are struggling with suicidal feelings. In a mental hospital severely depressed patients are sometimes seen who suddenly appear more relaxed and carefree, and are found having committed suicide at their first opportunity. It is almost as if they had made the decision and were waiting patiently for the first opportunity to carry it out and were relaxed and carefree after the decision and plans were made.

Schizophrenics also frequently commit suicide, contrary to popular opinion. They usually carry it out in an impulsive, symbolic and unpredictable manner without necessarily showing evidence of depression. A catatonically excited patient may jump through a window in panic, not necessarily in an effort to kill himself but in an effort to get away from a situation which he feels himself in. This may be in response to visual or auditory hallucinations or delusions. For example, a middle-aged man did not appear depressed but frightened to the point of near panic. He heard someone's voice accusing him of cheating on his income tax and of sexual indiscretion. Without warning he jumped through a second floor window and all but killed himself. He apparently did not want to die but tried to get away from the "voice" that was accusing him and almost killed himself in the act.

A paranoid patient may calmly and deliberately take his own life while feeling persecuted by others. For example, a young man progressively developed the idea that people were "against" him. He especially felt that the father of his girlfriend was "against" him and had the power to control his thoughts and actions. Although concerned, he was

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outwardly calm. He was found hanged in a room which he had rented for the purpose, after first carefully getting his affairs in order.

In still another type of schizophrenic the suicide may be a part of some elaborate delusionary system and may represent a symbolic act. It is in these cases that we frequently see bizarre methods of suicide or see the person dressed very carefully as if for a very special occasion. A middle-aged man became progressively more preoccupied with suicide. He was especially preoccupied with finding a method which could be employed which would leave no evidence as to the cause of death. He carried with him constantly a picture of his mother who had committed suicide when he was 13. He eloped from a locked ward of a mental hospital and was found dead several hundred yards from the buildings without leaving a clue as to how he got off the ward or as to the cause of his death.

It should be emphasized that not only the psychotically mentally ill commit suicide but the neurotically ill as well, with or without depression. For example, the case of a middle-aged woman who was definitely not psychotic in the ordinary sense of the word and was certainly not depressed. She was anxious, tense, and somewhat agitated. She had attempted suicide twice with barbiturates and once with carbon monoxide. While in the hospital following one of the attempts, she was getting along well and had been home for a day with her husband. While home she obtained a razor blade and brought it with her to the hospital. She was pleasant and friendly in the hospital during the next two days and on the second night cut both wrists with the razor blade. She was found in an exsanguinated condition by the nurse whom she called when the bleeding stopped apparently because she was in severe shock.

I should like to emphasize that although it is commonly thought that people who talk about it a great deal are not likely to commit suicide, this is most certainly not true. It is true that people who threaten to punish someone with their suicide, or who appear to be putting on an act may not necessarily wish to die. However, the talk of suicide is usually the result of genuine suicidal impulses and results frequently in serious attempts if not successful ones. The selection of suicidal attempts as a means of punishing others or of getting attention seems most certainly related to pathological suicidal drives. Even if we should consider the suicide an accident, the death is real nonetheless. When these trends are present in patients they need treatment as much as any, and it is not unusual for these people to make numerous attempts and finally succeed if not treated. A middle-aged woman had talked of suicide and had been previously hospitalized because of it, but her husband had signed her out of the hospital against advice. He said although she talked about it a great deal he was sure she wouldn't carry it out. She was tense, anxious, and fearful but showed no evidence of depression. Her husband spent most of his time with her but on one occasion left her alone for approximately half an hour. He had a "premonition" while away that he left his razor blades available to his wife by forgetting to lock them up as he usually did. When he returned home he found her lying in a partially-filled bathtub with her throat cut into her trachea.

A physician frequently needs to make the decision of whether a patient is a suicidal risk or not, or as to the degree of risk that is present. This decision is frequently difficult and calls for a close cooperation between psychiatry and the various branches of medicine. As the surgeon and the internist pool their knowledge when there is a pain in the abdomen of a patient to try and arrive at a conclusion whether to operate or treat the patient medically, so the psychiatrist and any other medical man may need to pool their knowledge when the question of suicide is present. Indeed the psychiatrist will not always be able correctly to predict, but he should be able to offer helpful judgment. I should like to give the following signs, however, which are of special interest and, when present, need to be carefully evaluated. They are frequently the expression of pathological suicidal impulses.

1. Depression with expressions of self-accusation, hopelessness, retardation or agitation. No person who presents these symptoms should be lightly regarded, especially in the involutional period of life.

2. Any talk of suicide, either of committing suicide or unsolicited denial of it. Such denial of intent is frequently as important as the expression of the wish to commit suicide. It may be evidence of an inner struggle and frequently the stronger the denial, the stronger the struggle.

3. Concern that others might commit suicide is frequently an evidence that the person, himself, is preoccupied with suicide but projects his concern onto others.

4. Previous attempts at suicide. It is a simple rule that the likelihood of suicide is greater in a person who has made a previous attempt.

5. Close relationship with someone who did commit suicide. It is frequently observed that people who have experienced the suicide of an important person in their lives during the formative years are more likely to commit suicide.

6. Excessive and unrealistic worry over physical health, frequently in combination with excessive concern over sleeplessness, fear of losing the mind or of losing self-control. These are frequent expressions of conflict over suicidal impulses in patients.

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CORONARY OCCLUSION AND MYOCARDIAL INFARCTION*

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IN THE PAST ten years the treatment of coronary thrombosis with or without myocardial infarction has been in a state of flux. The classic report by Wright et al[1] which was written under the auspices of the American Heart Association served to crystallize the varied modes of therapy which include rest, sedation and anticoagulants. Anticoagulant therapy appeared to appreciably alter mortality and morbidity by reducing thromboembolic complications, and its use has been generally accepted in modern therapy.

In general, smaller non-teaching hospitals appeared to be slow in accepting what may appear to be radical therapy i.e. anticoagulant therapy. Consequently, almost all the cases of coronary thrombosis with or without myocardial infarction treated at the Newport Hospital in the five-year period from January 1, 1946 through December 31, 1950 were in the group not treated with anticoagulants. Twelve (6.4%) received anticoagulant therapy (dicumarol, heparin).

The present series included 188 cases of which 131 (70%) were males and 57 (30%) females, a ratio of 2.3 to 1. The age distribution is graphically demonstrated in figure 1. There were 2 cases

Fig. 1 Age distribution of 188 Cases of Myocardial Infarction

(1%) under thirty years of age, eight cases (14.8%) in the third decade of life and the remaining 178 cases (94.2%) were over forty years of age. The sex and age incidences paralleled reports in the literature.[2]

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The mortality rate was 40.4% (76 cases). The majority of deaths occurred within two weeks after the coronary occlusion, and totalled 56 cases (73.7%). Of these, 26 cases (46.4%) died within twenty-four hours and 30 cases (53.6%) within the two-week interval. The residual 20 cases were spread over a three-month period, one death occurring at the end of this time. The mortality rate of 40.4% is high when compared to 23.4% for the control group in Wright's[3] series. Doscher et al[4] reported the combined mortality rate of over 4,000 cases in the literature was 23.5%.

Atherosclerosis (arteriosclerotic heart disease) was the basic etiology in 187 cases (99.5%); luetic heart disease with aortic insufficiency appeared to be the cause of myocardial ischemia in one case. Exotic causes of coronary insufficiency or myocardial infarction were not demonstrated in this series.

Electrocardiograms were available in 112 cases (59.6%). 49 cases (43.8%) were without evidence of classical myocardial infarction, but showed significant T-wave changes that were consistent with coronary insufficiency. Figure 2 reveals that 33

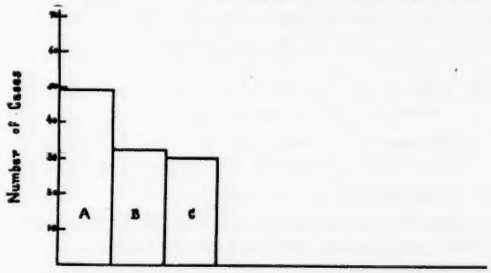

Fig. 2. Distribution of 112 Electrocardiographic Findings.
A = coronary insufficiency B = anterior myocardial infarction
C = posterior myocardial infarction.

cases (29.5%) were in the anterior myocardial infarction group (or subdivision) and 30 cases (26.8%) were in the posterior myocardial infarction group (or subdivision).

Cardiac decompensation was present in 24 cases (12.8%). Diabetes mellitus was discovered in 6 cases (3.2%).

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There were no reported cases of peripheral venous thrombosis, pulmonary or peripheral arterial embolism. Extension of a myocardial infarction was observed in 8 cases (4.3%); new infarctions were recorded in 5 cases (2.7%). The total percentage of thromboembolic complications in our series was 7%. This is very low, and, undoubtedly, if the autopsy percentage (8%) were higher, additional complications would have been uncovered. Myocardial rupture was noted in two cases (1%).

Treatment followed accepted methods. The vast majority of patients received bed rest, but with emphasis on early ambulation. Morphine or demerol was used in 150 cases (80%). Barbiturates were used as indicated in 83 cases (44%), particularly during the latter weeks of hospitalization. Oxygen therapy was used in 93 cases (49.4%). Infusions were given in 10 patients (5%) for surgical problems, and not for the treatment of cardiovascular shock. Digitalis preparations were used in 6 cases (25%) of those evidencing congestive failure. They were also used in 14 cases (7.5%) without evidence of congestive failure. Quinidine was used in 4 cases (2.1%), aminophyllin in 30 cases (15.4%) and atropine in 16 cases (8.5%). Anticoagulant therapy (dicumarol or heparin) was used in 12 cases (6.4%).

SUMMARY AND CONCLUSIONS

188 cases of coronary occlusion at the Newport Hospital in the five-year period from January 1, 1946 through December 31, 1950 are reviewed. It is pointed out that only 12 (6.4%) received anticoagulant therapy. Therefore, for practical purposes, this report summarizes the findings of a group not receiving anticoagulant therapy:

1. The sex ratio is 2.3 to 1 in favor of the males.
2. The greatest percentage (94.2%) of cases is older than 40 years of age.
3. The mortality rate is 40.5%; 76.3% died within two weeks after the onset of a coronary occlusion.
4. Arteriosclerotic heart disease is the pathological process in 99.5% of the cases.
5. Electrocardiograms are available in 59.6% of the cases and reveal the patterns of coronary insufficiency in 43.8% anterior myocardial infarction in 29.5% and posterior myocardial infarction in 26.8% of the cases.
6. Associated complications are cardiac decompensation in 12.8% and diabetes mellitus in 3.2% of the cases.
7. Thromboembolic complications are 7%.
8. Treatment follows accepted lines, except for the slow acceptance of anticoagulant therapy.

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SOME CLINICAL ASPECTS OF SUICIDE

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It is not always easy to prevent suicide when pathological suicidal drives are present. It may, in fact, at times be impossible; however, every effort must be made. When one suspects suicidal drives as being present, the matter should be frankly and understandingly discussed with the patient. Rather than being upset, patients are frequently reassured. They realize that if the physician is aware of such impulses being present, he will protect them from themselves. In this way, the physician lends immediate protective support to that portion of themselves which is trying to suppress the suicidal impulses. Anyone in whom definitely known suicidal drives are present, should be under psychiatric care and be observed 24 hours a day until a careful evaluation can be made. I should like to emphasize that suicidal impulses should not be viewed as isolated phenomena but as a part of a total picture of an individual with all of his strivings and conflicts.

I should like to emphasize again that no threat of suicide, or any evidence of suicidal drives, should be taken lightly. Above all, we should not depend on the judgment of a mentally disturbed patient that he will not commit suicide, unless a careful psychologic evaluation has been made.

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VIDEOTHERAPY AS AN OFFICE PROCEDURE

BARRY B. MONGILLO, M.D.

The Author. *Barry B. Mongillo, M.D., Visiting Physician, Outpatient Department, Neuropsychiatry, Charles V. Chapin Hospital, Providence, R. I.; Assistant Physician, Department of Neurology and Psychiatry, Rhode Island Hospital.*

MY RESULTS with videotherapy parallel fairly closely the comments of Miguel Prados, M.D.[1] Carefully selected films may be of great benefit in psychiatric therapy and many other fields involving interpersonal relationships. However, the therapist must understand their indication and must be prepared to handle reactions produced by the films.

Video Treatment is a New Treatment Procedure and a Treat

What is the usual Medical approach?

1. Because of the old traditional approach, patients have come to expect operations, pills, and injections for any ailment and of course, in the opinion of the patient, no diagnosis is complete without x-rays.
2. Modern treatment is handicapped by ignorance, prejudices and the current stigma and attitudes. The parents continue to expect the psychiatrist to take over their problem child without assuming any responsibility and then getting their child back brand new, free of fears, tantrums or panics, and, of course, sweet as an angel in one treatment. This new therapy, through dramatized feelings, scenes of abnormal behavior and depicted unwholesome attitudes are directed to the problem child and the parents. This is done through the skill of the cartoonist in the film, "Johnny Learns His Manners," which is particularly suitable for the young child with conduct disturbances, and the words of the commentator and doctor as they denounce or censor the deeds of the problem child on the screen.

What is Embodied in Videotherapy?

Videotherapy is a form of *play analysis and therapy*. Play as a means of investigation is peculiarly appropriate, since it is the normal mode of expression and pursuit of pleasure of the child.

[1]Prados, Miguel, M.D., McGill University, Montreal, Canada: AM.J. ORTHOPSYCHIAT. (303 Lexington Ave., New York 16, N. Y.) 21:36-46, Jan., 1951.

Understanding the psychology of the child through observing his play is not a new technique. Rosseau entertained the idea as a concept.

Play therapy as applied to the psychopathology of the child, however, is a more recent development dating back approximately twenty-five years and was pioneered by Von Hug Hellmuth.

Testing, Investigating and Treatment Programs

With the surface thus far having only been scratched, and in the rapidly expanded area of projective techniques as a means of exploring and reintegrating human personality, patients have been subjected to a wide range of experiences and tests (those that include visual or creative responses). Projective techniques may be divided into three groups:

1. Those that like the Rorschach and Thematic Apperception Tests focus the patient's responses on specially prepared visual material,
2. the other more fluid and spontaneous projective techniques that are to be found in the varients of play therapy, and
3. Videotherapy which embodies both groups, 1 and 2.

The use of such creative arts as music, drama, dance, sculpture and painting for the purpose of diagnosis and therapy belongs in the second group of more flexible projective techniques.

I offer to the medical profession in particular an additional diagnostic and therapeutic approach which I believe belongs to all three groups and which I prefer to call Videotherapy. This procedure is applicable to grown-ups as well as children.

We know that early symptoms of childhood maladjustment can disguise themselves behind formal school procedures or all too often go undetected. A dangerously recessive and introverted child, the "good child," can easily pass unnoticed beneath the passive obedience of what the teacher all too often regards as a "good pupil." Another child with tendencies to compulsive behavior may all too easily conform to those stereotyped responses that satisfy school requirements but limit the child's more balanced normal development. Tendencies to neurotic, restless, hyperkinetic, or predelinquent behavior are likely to increase under the requirements of

continued on next page

silence and immobility at home or in classroom procedure, and are seen in the office when the child is brought in for treatment. But, the very same child can sit still and attentive and remain silent for one hour or more while you *"treat"* with videotherapy.

Because such maladjusted children, and of course, adults too, are often unaware of the cause of their neurotic behavior or of the fact that they are being studied, the approach of play therapy and other projective techniques particularly videotherapy becomes valuable in revealing unconscious motivations.

There are many ways in which any art or play experience can be used in psychotherapy either as a passive experience with the patient as a spectator or as an active experience with the patient as creator, one need merely roll out the projector and every child becomes intrigued and a willing assistant.

Advantages and Accomplishments Gained through Videotherapy

1. It serves as a recreative cathartic experience for the patient.
2. It serves as a recreative cathartic experience for the parents.
3. Fosters the development of transference.
4. Means of instituting passive psychotherapy.
5. Means of motivating and instituting passive experience in play therapy.
6. Serves as a means of providing active experience in play therapy.
7. As an adjunct to other therapeutic means.
   a. Affords an opportunity for identification (in the movie, "Johnny Learns His Manners." The boy is first rejected then adopts wise compensations through identifications and self-discovery).
8. As a means of getting information for diagnosing.
9. As a means of getting information for prognosis.

Sample Showing

The following is the sample showing of the story, "Johnny Learns His Manners," an animated instructive cartoon production which is of great value in treating children with behavior problems. Comments may be made by the therapist during the showing and samples of the therapist's remarks are represented by parenthesis.

Our story begins with a view of a drawing board and an artist's hand completing the sketch of a small, pretty house. The hand moves over to another section of the drawing-board and sketches the eyes, ears, nose and mouth as a little boy's head emerges.

The narrator begins the story of Johnny, as the artist rapidly draws arms, legs and a body to complete our hero.

The scene shifts to Johnny, asleep in a room that is completely untidy. His clothes have been thrown all over and his toys litter the floor. It is easy to see that Johnny is a very untidy little boy, although the narrator assures us that he has often been asked to take care of his things.

When Johnny awakens, we begin to get some idea of the cause of the trouble. Johnny's "Badself," (badself may be said to represent conflicts, spoiled child, the devil, temptation, evil, etc.), a nasty imp whose mission in life is to get Johnny into trouble, urges him to throw his pajamas down anywhere. Johnny has a "Goodself" (can be said to represent the conscience) too, who pleads with him to behave as his mother has asked him to. But "Badself" wins out, and the pajamas are thrown on the floor.

Johnny next enters a tidy bathroom. At the urging of "Badself," he squirts water over everything, mashes the toothpaste tube and soils all the towels. "Badself" is in an ecstasy of delight, (for the moment; the good always triumphs in the end). Even though "Goodself" cautions Johnny that by acting like a little pig he runs the danger of turning into one, Johnny's reply is scornful. But, as Johnny leaves the bathroom, his hands and feet turn into those of a little porker!

Unaware of the change in himself, Johnny appears at the breakfast table. We now discover that his manners are terrible. His mother is unhappy, and "Goodself" pleads with Johnny. But he slouches over the table, stuffs his food, and spills his milk. Now pig's ears pop out on his head. "Goodself" desperately tries to caution Johnny about turning into a pig, but is imprisoned under a water tumbler by "Badself." When Johnny leaves the table a snout sprouts on his face in place of his nose.

We follow Johnny to the baseball diamond where other boys are at play. (We learn that he has become unruly, selfish, and a sorehead.) A little fellow named Tommy is at bat, but Johnny takes the bat away from him. Tommy's companions protest, and even "Goodself" tells Johnny that his conduct is wrong. Johnny's reaction is to brush "Goodself" away as he levels off to hit the ball. A close-up view of Johnny leaning over shows that he has now acquired a curly tail!

The game progresses. A new difficulty arises when Johnny is thrown out at first base. (Johnny's protest of the decision is evidence of emotional immaturity and of having been spoiled.) Johnny will not accept the decision and he starts an argument which, alas, results in a fight. The other boys desert Johnny with a final taunt, "You're nothing but a pig!"

Left to himself, Johnny has no choice except to go home. On his way he passes a pig farm full of very dirty little pigs. Because the gate is open, and because they had never before seen a pig with clothes on, they trail out after Johnny. His efforts to "shoo" them off are to no avail. Johnny escapes his unwelcome companions only by racing into the garden of his home and slamming the gate behind him.

Johnny now looks about for his dog, Rover. He is certain that he has no more true a friend than Rover, and that the little dog will approve, no matter what Johnny has done. Johnny whistles, and we see Rover run out to see his master. But at the sight of a transformed Johnny, Rover halts, howls and scampers off to hide in the bushes.

Thoroughly dismayed by Rover's reaction, Johnny now enters his house. Johnny passes a wall mirror into which he glances. A light of frightened understanding dawns in Johnny's eyes. He stares back at the porcine image in the glass and hurries off to find his mother.

Johnny's mother is completely sympathetic. (Having acquired psychological insight through treatment, she encourages him to depend upon himself.) But she explains that he has come to resemble a pig because of his behavior and attitude toward others. To look like a little boy again, mother points out, Johnny will have to learn to be considerate, neat and thoughtful. Then, to illustrate her point, Johnny's mother asks him to look at some new home movies with her.

Together with Johnny, we see a motion picture showing champions in many fields of sport. This followed by scenes of cadet life in West Point. Mother asks Johnny to note how neatly their rooms are kept and how well-mannered they are at all times.

Johnny is deeply impressed by what he has seen and needs no further urging to put his new resolutions into practice. Rushing to his room, he hangs his clothes and puts his playthings away neatly. Johnny's hands and feet once more take the place of the little hooves. Elated by this improvement, Johnny rushes to clean the bathroom. Glancing into the mirror, he is rewarded by the discovery that his own hair has grown back again. Johnny now knows that he is on the right track.

Even Johnny's table manners now show improvement. But evil "Badself" makes the final attempt to lure Johnny back to his former ways. Johnny, however, has learned his lesson. He imprisons the imp in the sugar bowl.

Except for his snout, Johnny now has been restored to his little boy self again. He returns to the baseball field, where the other boys are at first reluctant to allow him into their game. Johnny offers to let Tommy use his new bat, lends Freddy his glove and urges Billy to pitch with his new ball. The boy's resentment fades. As the game progresses Johnny has a real opportunity to prove his sportsmanship.

Hitting what looks like a certain home run, he sprints around the bases and arrives at home plate at the same instant as the ball. The catcher calls Johnny "out" and all the other boys gather about, expecting a fight. But their fears prove to be unfounded as Johnny pleasantly concedes that he could not see the details of the play. Johnny even congratulates the catcher on a swell catch!

The confidence of the other boys in Johnny has been restored. He is elected captain of the team. (The good self triumphs. It pays to grow up and to be good.)

Happy as he can be, Johnny wipes away a furtive tear and the last of his pig features vanish. When the game is finished, Johnny returns home to find his mother and Rover waiting for him in the living room. Rover shows his unbounded affection by leaping up to lick Johnny's little-boy features. His mother beams proudly as Johnny tells her that it's more fun to be a little boy than a pig!

The patient grows through mastering conflicts and is able to reach maturity, gets recognition through normal effort and good behavior.

We say then that Johnny becomes unruly, a sorehead in the film and as is often the case in real life when children are given everything they want by their parents and when in school and in later life, they may become disobedient, nervous and upset because other people will not cater to them or treat them as their parents did. Of course a rigid, austerely moral home life or one lacking in sympathy and understanding may result in rebelliousness and delinquency as much as the children from parents who are too indulgent and overprotective. In the latter case however, the children are more apt to become dependent, insecure, withdrawn and afraid as depicted on the screen.

With grown-ups as well as with children, mental health and happy living represents nothing more than applying mental hygiene at a time when it does most good, that is in the early years of life and following a middle course between complete repression of our natural impulses and giving free reign together with the necessity of understanding our emotional reactions and the means of preventing the development of abnormal traits.

Another film showing, particularly applicable to demonstrate dangers and underlying psychopathology of overdependency is the film, "*Overdependency,*" which relates, "a story of Jim, a young commercial artist, who uses illness as an escape from responsibility. When the doctor can find no physical causes of his illness, he tries to find the emotional causes and discovers that Jim

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The RHODE ISLAND MEDICAL JOURNAL

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FOREIGN MEDICAL SCHOOLS

LAST DECEMBER we editorialized on the question of medical education in American and foreign schools, and we concluded with the statement that "the student who goes abroad for his medical education should not look forward to any relaxing by state licensure boards in this country of our standards merely to meet the convenience of any particular individuals."

The discussions, as reported in the BULLETIN of the Federation of State Medical Boards of the United States, that attended a resolution proposing that the American Medical Association "find immediate ways and means to officially appraise and classify all foreign medical schools," bears out the points made by us. The Federation meeting was held in Chicago in February, and the problem of foreign medical schools warranted much comment.

In the first place the American Medical Association does not approve foreign medical schools. Through its Council on Medical Education it secures information on these schools, carefully evaluates the investigative reports submitted, and then issues what it simply calls "a list of foreign schools." The Council on Medical Education does mention in its preamble that it is its recommendation that graduates of these schools be considered on the same basis as graduates of American schools.

As pointed out in the discussions by the licensure board delegates from the States, the foreign training does not measure up to that given in the medical schools of this country. For example, Doctor Ezell, secretary of the New York Board, reported that examination records indicate 60 to 75 per cent of failures by graduates from foreign medical schools, and that, to him, does not mean "approved or equivalent education." As a possible solution he advances the thought that university medical schools set up training programs that may be acceptable to the State Boards concerned, thus paving the way to give these foreign students the needed further training.

And as stated by Doctor Moore of Chicago at the meeting, foreign graduates do not receive the same training in Switzerland as those who expect to practice in that country, and although this situation is to be remedied in the future, it does point up the attitude of some of the foreign countries regarding the American student seeking his medical education in their schools.

Of particular significance, however, is the viewpoint expressed by Dr. Rappleye of New York City, to the effect that there were 630 foreign medical graduates serving as interns and residents in hospitals in New York State and that these numbers

were increasing and would soon equal the number of graduates each year from the nine New York medical schools!

Another alarming fact that he cited was the increasing percentage of alien physicians on the hospital staffs in New York and New Jersey, 22% in the former and 48% in the latter. "This influx," he reported, "of foreign-trained practitioners as well as the large number of American students now in foreign medical schools has added to the difficulties of properly evaluating the qualifications of such graduates for practice in this country."

There is no easy solution to the problem. The cost of surveying medical education in 45 schools in this country represented an investment by the American Medical Association of several hundred thousand dollars, and where the funds would come from to make an on-the-spot inspection of medical schools in Europe to determine their standards as compared with ours, is an unanswered question. Even if there were such funds available the possibility that the foreign schools would welcome, or even accept such investigations, is to be doubted.

When the World Congress on Medical Education meets next August in London we hope that the foreign medical school problem will be presented by the American delegation. Certainly until such time as we have information as reliable as has been compiled by the Council on Medical Education of the American Medical Association on the foreign schools it has listed, any state licensing board should proceed with extreme caution in evaluating the credentials of the graduate of the unlisted school.

TUBERCULOSIS CASE FINDING

The widespread publicity given in the press of new drugs to combat and control tuberculosis could result in a lessening of public interest in the search by voluntary agencies, such as our Providence Tuberculosis League, for cases of tuberculosis. This must not happen. Tuberculosis is not yet conquered. A persistent, continuing campaign must be continued to prevent and eradicate the disease.

And as our local Tuberculosis League has pointed out in its 47th annual report, x-raying for case finding is the first line of defense. Bearing out this contention the Providence League provided chest x-rays and advice to 6,341 individuals who visited the local office, and in addition took 22,215 small films through the facilities of its motor trailer.

Not alone has the problem of tuberculosis been attacked through this x-raying procedure, but many other pathological conditions of the heart and lungs have been uncovered with the result that prompt medical treatment has been undertaken. As part of the total health program, the tuberculosis case finding program with its chest x-ray diagnostic aid is of paramount importance to every citizen, and of special significance to the private practitioner.

TURNING BACK THE CLOCK

The end of April saw all of us turning our timepieces forward to take advantage of the daylight saving program. But about this time our editorial readings turned us back thirty-six years to the first issues of the Rhode Island Medical Journal as published in 1917. After a perusal of some of the articles and editorials of that day we hastily checked our calendar, our watch, and our eyesight to determine whether time had gone forward, backward, or had stood still.

Here are some of the items that made us wonder if 1953 was still 1917, and convinced us that the old saw about history repeats itself has more truth than anyone except a historian will admit:

". . . when any political philosophy begins to convert itself into acts and to write itself upon statute books in such fashion as to concern most intimately the lives of physicians and their patients, the pages of a Medical Journal are precisely the place to discuss it. The Legislature of Rhode Island is engaged in formulating for passage an amendment to the workmen's compensation act in so far as that act relates to the provision of medical attention for injured employees . . .

* * *

" . . . the most important of the amendments for which we fought have been granted. The medical profession may justly feel that a notable victory has been achieved, and that the fairness of our contention—that the former act worked a great hardship on the physician—has been recognized by the lawmakers. This is also a significant victory for the workingman. The inalienable right of every man, in time of injury or illness, to summon a physician in whom he has confidence, is restored to the injured employee . . ."

And on the same subject of workmen's compensation amendments we found a prominent member of the legal profession presenting a paper before the Medical Society in 1917 in which he stated:

"The establishment of an industrial accident board would mean that the medium would be constantly at hand whereby disability cases would receive prompt investigation and attention, and the welfare of the injured person who is unable as a rule to look after himself would be expeditiously and properly cared for . . ."

Recently we editorialized on the subject of physicians as members of hospital boards of trustees, and an answer to that editorial appears in this issue. But in 1917 our editorial writers had already presented the topic with the comment included that:

"The duties of the staff should not be restricted to the care of patients under the supervision of the Trustees and controlled by rules of action formulated by them . . . a professional member of the Board should represent the staff . . . (for) the lay Trustees of any hospital cannot estimate such services (professional) satisfactorily . . ."

And on the subject of fees and the rising cost of living we found that what was said thirty-six years ago could not be said better for today—

continued on next page

"Within the past two years the cost of living has risen beyond all precedent in this country . . . accompanying this increase in the cost of living has come a wage increase for most laborers, and of late the salary of many fixed wage earners has been raised. In this prosperity the physician, in common with most professional men, has not shared. Our cost of living has greatly increased and we have felt the burden also in the higher price of nearly all medical and surgical supplies . . . in addition, the present taxes are designed particularly to gouge the professional man . . ."

And on the subject of military preparedness we noted that

"As we are entering soberly into the great task of making the world safe for democracy, we must realize that proper sanitation and hygiene stand in the front rank of military activities . . . We should urge upon the President and the Congress that full authority and ample means be given the Medical Department to meet present responsibilities. We should also throw ourselves heart and soul into the task of securing a full enlistment of the medical profession in what promises to be our most important national business for some time to come."

Who said, "turn the clock forward"?

OUR ARGUMENT STRENGTHENED

"To the Editor, Rhode Island Medical Journal:

"I am writing regarding the editorial 'Hospital Trustees' in the last number of the RHODE ISLAND MEDICAL JOURNAL.

"Possibly you do not consider the Emma Pendleton Bradley Home a hospital. In everything but in name it is a hospital. For a number of years I was a member of its Board of Trustees, becoming Chairman of the Board of Trustees and continuing as such until I reached the age of seventy; when under the will of the Bradleys—Trustees could no longer serve.

"I am sending you this information not for any correction but simply so that historical facts may be kept on the record."

ARTHUR H. RUGGLES, M.D.

Since we got the above pleasant letter we have also had recalled to our attention the long service of Dr. Halsey DeWolf as a Trustee and President of the Board of Trustees of the Providence Lying-In Hospital.

We are really pleased that an inadverent remark in our editorial column has resulted in these two communications. It stresses the fact that leaders of our profession read our columns carefully and take the trouble to cooperate with us.

Dr. Ruggles cannot blame us too much, for, although the word hospital is one with beautiful connotations, "home" even surpasses it in this respect.

Although there is kindly criticism of the letter of our remarks the spirit of our argument is strengthened by these reminders. Other hospitals may well look upon the Bradley Home and the Providence Lying-In and be impressed by the accomplishments of these two institutions with doctors on their Boards of Trustees.

SOME CLINICAL ASPECTS OF SUICIDE

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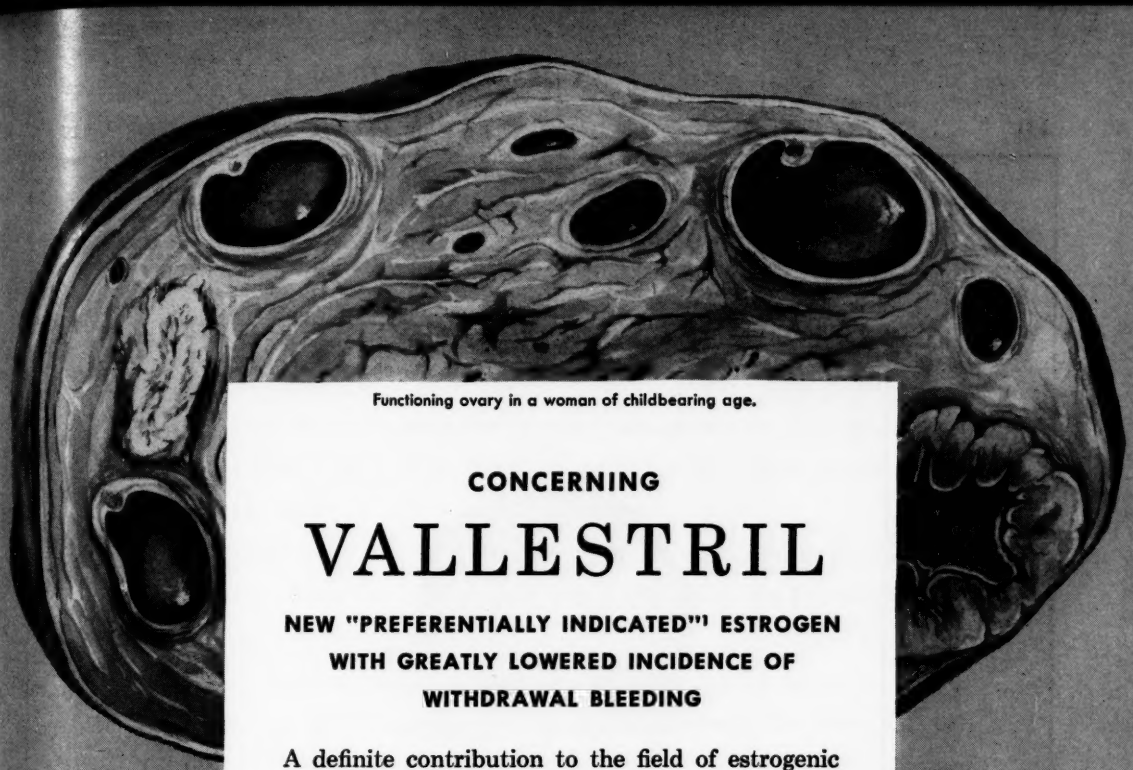

Functioning ovary in a woman of childbearing age.

CONCERNING

VALLESTRIL

NEW "PREFERENTIALLY INDICATED"[1] ESTROGEN WITH GREATLY LOWERED INCIDENCE OF WITHDRAWAL BLEEDING

A definite contribution to the field of estrogenic therapy is offered in Vallestril.*

In a recent controlled clinical study covering a period of two years, Sturnick and Gargill[1] reached these conclusions:

Vallestril "is an effective synthetic estrogen that is singularly free from toxic effects and complications, especially uterine bleeding. . . . Clinically, it quickly controls menopausal symptoms, ..."

Vallestril is available in scored tablets of 3 mg. For treatment of the physiologic or artificial menopause: 3 mg. (one tablet) twice daily for two weeks, then a maintenance dose of one tablet daily for an additional month or as long as continued administration is required.

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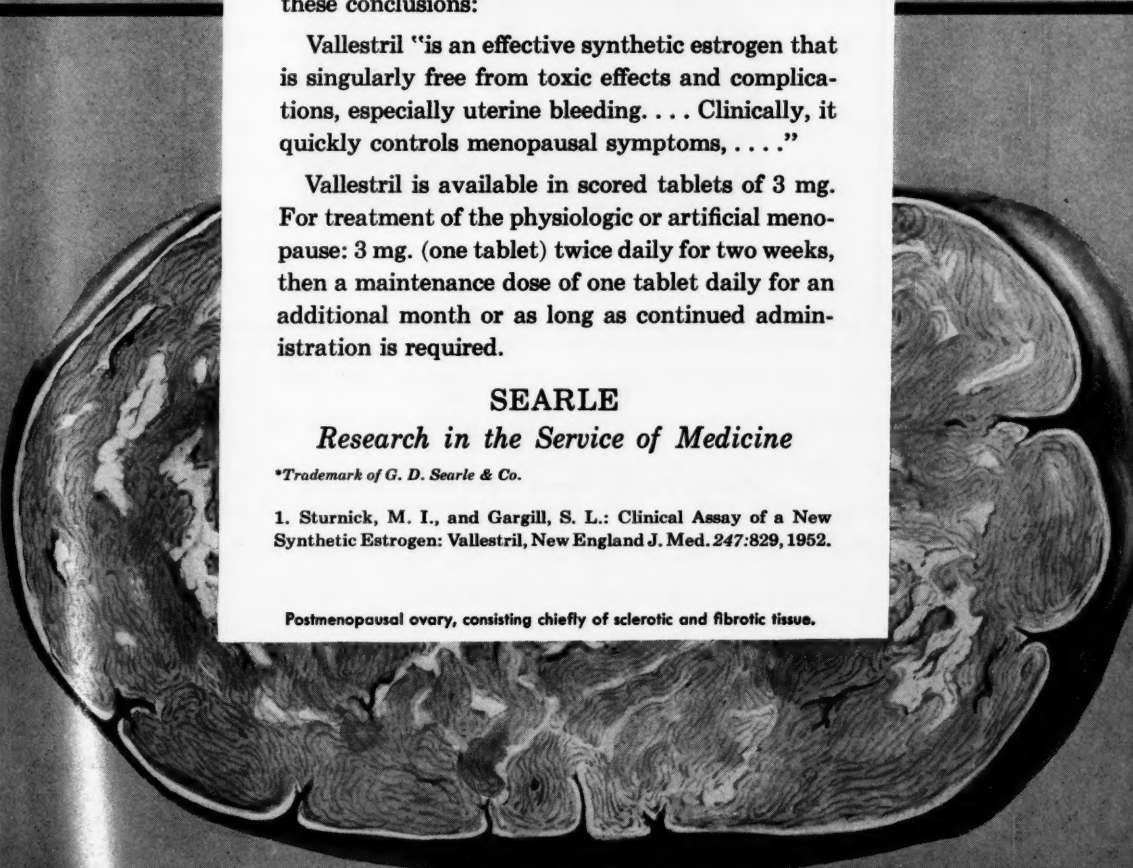


Postmenopausal ovary, consisting chiefly of sclerotic and fibrotic tissue.

EARL F. KELLY, M.D.

of Pawtucket, R. I.

President of the Rhode Island Medical Society

1953 — 1954

PRESIDENT'S MESSAGE

I AM DEEPLY GRATEFUL for the honor conferred on me as President at this Annual Meeting of the Rhode Island Medical Society. This Society, as you know, is the ninth oldest state society and has grown to a membership of over eight hundred men in all fields of medicine who work in the various hospitals in this state.

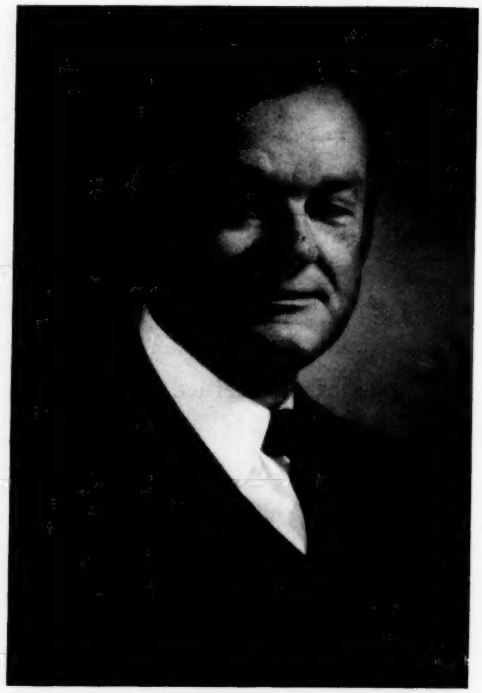
I am cognizant of the fact that medicine is changing insofar as the treatment of the patient is concerned, with greater hospital facilities and greater improved advances in the use of antibiotics. Also, the advancements that have been made in surgery that have changed many of our concepts.

The doctor is no longer in a class by himself but has part of an over-all picture that is continually changing. We as physicians must keep up to these changes. We are servants of the public and we must have the confidence of the public for our skill and for the maintenance of the problems of life. In turn, the public must rely on our skill and knowledge. It is very obvious from the above statements that we must progress through life together, side by side, and not in different avenues of thought.

We shall only be successful in our aims in life if we are always with each other, and we must have trust in each other if the patient is to live and if the doctor is to be successful in maintaining a patient's life.

The Rhode Island Medical Society was not founded for a few members, but for all, and I wish to say in my term of office as President any suggestions from any member of the Rhode Island Medical Society will be recognized, also that at any time any member of the Medical Society can, and should, partake in the doings of his society. We will derive more benefits from the Society if we have the cooperation of all the members rather than a few. We shall keep the high standards of the profession as they have been handed down throughout the years by our forefathers in the field of medicine, in our association with this noble organization, the Rhode Island Medical Society.

EARL F. KELLY, M.D., *President*



HERBERT E. HARRIS, M.D.
of Providence, R. I.
Vice President of the
Rhode Island Medical
Society 1953-1954

HENRI E. GAUTHIER, M.D.
of Woonsocket, R. I.
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GAMMA GLOBULIN FOR POLIOMYELITIS

— *Statement of the National Foundation For Infantile Paralysis* —

(*April 20, 1953*)

THE NATIONAL FOUNDATION for Infantile Paralysis makes the following statement upon the recommendation of its Advisory Committees on Research and Education:

"The Office of Defense Mobilization, a governmental agency, has been designated the allocating authority for the nation's entire supply of gamma globulin. Inasmuch as this blood fraction is effective in preventing measles, infectious hepatitis and poliomyelitis, and because this substance is in very limited supply, allocation of the nation's stockpile through a central agency was decided upon as the most effective way to prevent the greatest number of cases of these diseases.

"We have just learned that the Office of Defense Mobilization has announced its plan for allocating gamma globulin for use against poliomyelitis. The basis for the plan as announced was recommended by a special panel appointed by the National Research Council, a quasi-governmental agency.

"We note with some concern that in accordance with this plan, the greater part of the nation's stockpile of this scarce material may be used in a manner for which direct proof of efficacy is lacking. Reference is made here to the recommendation that gamma globulin be administered to household and other intimate contacts of patients suffering from poliomyelitis and, in certain circumstances, even to contacts of individuals suspected of having poliomyelitis.

"The field trials conducted during the summers of 1951 and 1952, with financial support of the National Foundation for Infantile Paralysis, demonstrated that gamma globulin, when administered during an epidemic of poliomyelitis to individuals in those age groups subject to greatest risk, provides some temporary protection against the paralytic form of this disease. Whether or not gamma globulin will be equally effective when used in some other manner is unknown. The field trials further provided suggestive evidence that those individuals who develop poliomyelitis following administration of gamma globulin develop a less severe form of the disease.

"While it is true that in a population group made up entirely of individuals who are contacts of persons with poliomyelitis, there develops subsequently an unusually large number of cases of this disease, it is also true that approximately 75 per cent of these 'secondary' cases occur within six days of the time the first case in the family has been diagnosed. Whether or not gamma globulin will prevent poliomyelitis when it is administered to contacts of diagnosed cases is unknown.

"We know that gamma globulin is not effective if administered to patients after signs of the disease are apparent. We also know that most, if not all, contacts of cases of poliomyelitis are already infected with the virus by the time the first case in the family has been diagnosed. In fact, there is good reason to believe that such individuals might have been infected for a period of several days. IF the blood fraction is to be administered to contacts of cases, the important and as yet unanswered question is 'Has the disease already advanced beyond the point where gamma globulin can prevent paralysis?' There is good reason to believe that there will be many contacts of cases of poliomyelitis who will become paralyzed even though they receive gamma globulin.

"The National Foundation's Advisory Committees on Research and Education have heretofore recommended and continue strongly to recommend that the major portion of the nation's stockpile of gamma globulin, available for use in poliomyelitis, be reserved for mass injections of children in the most severe polio epidemics of 1953. This recommendation is made because it is the only method so far proven to be effective against poliomyelitis. The Advisory Committees recommend further that the smaller portion of this scarce material be used in conjunction with contacts of diagnosed cases of poliomyelitis. It is hoped that, in connection with this latter use, adequate studies may be carried out so that we may learn whether or not gamma globulin employed in this manner can prevent paralytic poliomyelitis effectively."

The National Foundation stands ready to assist State Health Officers who may elect to employ community-wide injections of gamma globulin in an effort to halt an epidemic of poliomyelitis. It is prepared to provide specially trained personnel and such items of equipment as would not ordinarily be available in many communities.

oral penicillin which can be given with meals

PERMAPEN ORAL SUSPENSION

Palatable, easy-to-take peach-flavored Permapen Oral Suspension will maintain constant demonstrable blood levels of penicillin in most patients when just one teaspoonful is given every eight hours. These blood levels are independent of the relation of dosage to meals — in fact, Permapen may be given with meals without loss of efficacy.

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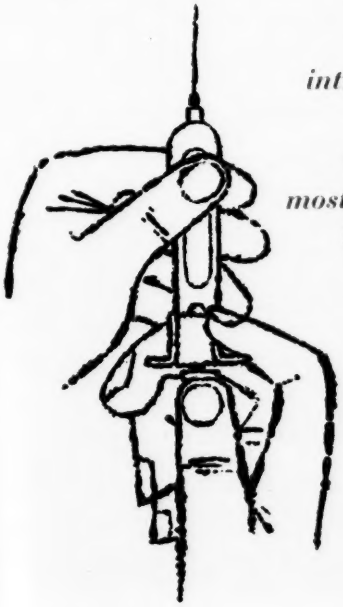

intramuscular penicillin which gives most prolonged blood levels

PERMAPEN AQUEOUS SUSPENSION

Free-flowing, easy-to-give Permapen Aqueous Suspension can eliminate the Streptococcus carrier state in most rheumatic fever patients because just one injection will produce demonstrable blood levels in almost all patients for 14 days or longer—levels prolonged far beyond those attainable with other penicillin compounds.

Supplied: In sterile, single-dose disposable Steraject* cartridges, 600,000 units each, with foil-wrapped, sterile needle.

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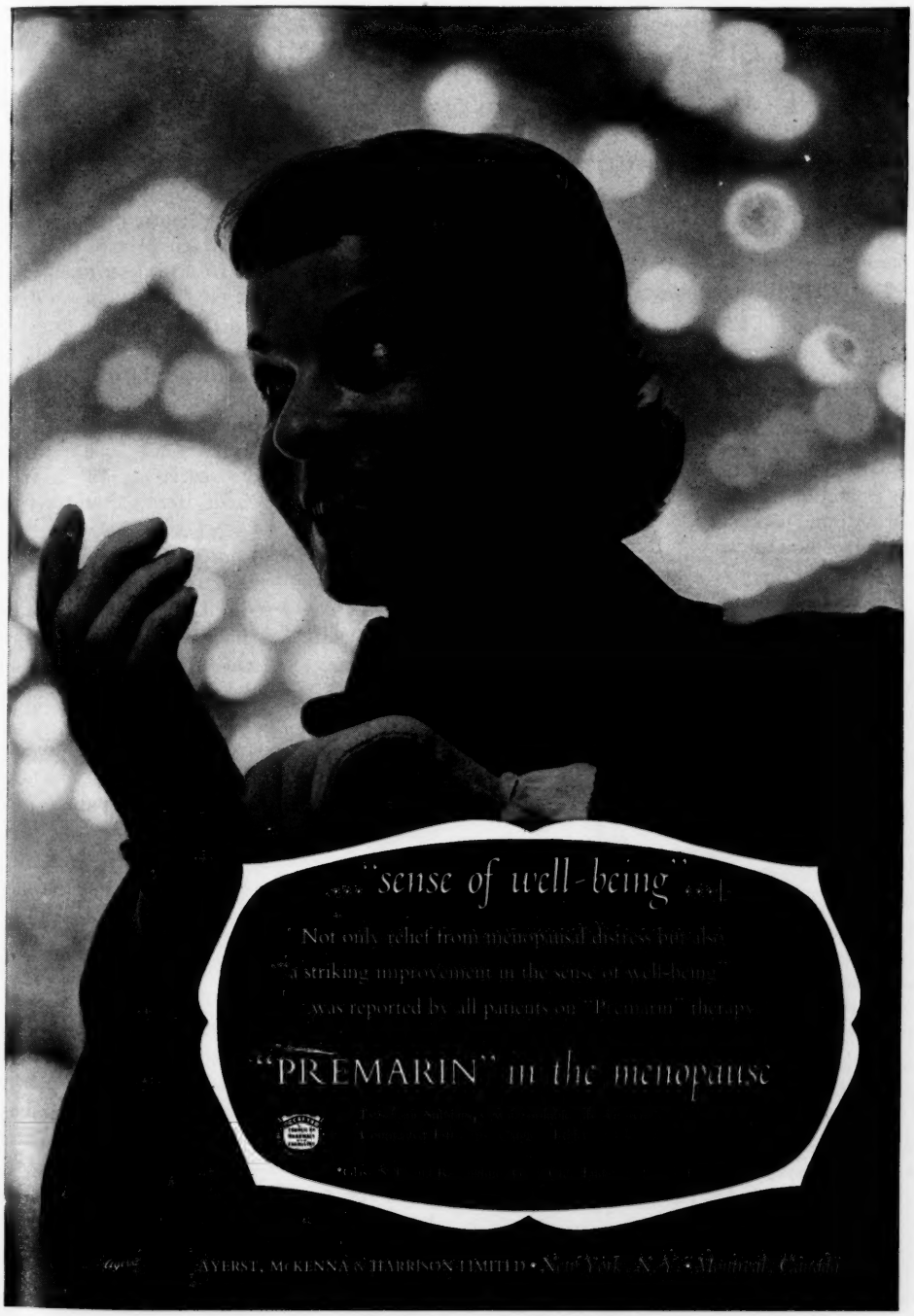
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Not only relief from menopausal distress but also
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was reported by all patients on "Premarin" therapy
"PREMARIN" in the menopause
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DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, April 6, 1953. The meeting was called to order by the President, Alfred L. Potter, M.D., at 8:30 p.m.

The reading of the minutes of the previous meeting was omitted with the approval of the members in attendance.

The Secretary read an announcement from the Rhode Island Society of Mental Hygiene extending an invitation to all physicians to attend the Second Arthur Hiler Ruggles Oration to be given at Butler Hospital on May 8, 1953.

The Secretary reported that at a recent meeting of the Executive Committee the following actions were taken:

1. The report of the Treasurer was reviewed. Appropriation was made of a gift to Mr. Comstock, building superintendent, and Mrs. Comstock, on the celebration of their 50th wedding anniversary.
2. Plans for the annual dinner and golf tournament of the Association, to be held on June 17, were approved.
3. A report on the work of the Medical Bureau was received and reviewed.
4. The Committee voted to purchase for the Association, a physician's bag, with equipment, to be presented to Rescue Unit No. 2 of the Providence Fire Department.
5. The Committee authorized the Group Insurance Committee of the Association to investigate and report on the problem of physicians liability insurance.

The Secretary reported that the Executive Committee recommends for election to Active membership Betty Burkhardt Mathieu, M.D. and Michael Greenwood Pierik, M.D., and to Associate membership Briand Beaudin, M.D. of Kent County and Henri E. Gauthier, M.D. of Woonsocket, and to Intern-Associate membership Horst Bertram, M.D. of the State Hospital.

Dr. Potter, for the Association, presented an equipped physician's bag as a gift from the Association to the Rescue Unit No. 2 of the Providence Fire Department. The gift was received by Lieutenant Arthur Brodur who expressed the appreciation of his unit and of the department for the contribution from the physicians of Providence.

The President reported on the meetings scheduled in the next two months for the Rhode Island Medical Society, the Rhode Island Academy of General Practice, the joint meeting of the Rhode Island Bar Association and the Rhode Island Medical Society, and the Annual Dinner and Golf Tournament of the Association, the last named to be held at the Rhode Island Country Club on Wednesday, June 17.

Dr. Potter called on Mr. Richter of the F. A. Davis Company, medical publishers, who had a display of books at the Library. Mr. Richter discussed the various publications available through his company and extended an invitation to the physicians to view the text books at the conclusion of the meeting.

The President introduced as the first speaker of the evening Norman L. Loux, M.D., Clinical Director at Butler Hospital, who spoke on "Some Clinical Aspects of Suicide."

This unusual subject was well received and stimulated an active discussion folowing the meeting. The paper will be published in the RHODE ISLAND MEDICAL JOURNAL.

The second speaker was Arthur E. O'Dea, M.D., Research Fellow in Pathology and Legal Medicine at the Department of Legal Medicine at Harvard Medical School, who spoke on "Medicolegal and Pathological Aspects of Suicide."

Dr. O'Dea presented some very practical aspects of the subject and showed numerous and extraordinary lantern slides of certain suicidal cases. This paper will be published in the forthcoming issue of the RHODE ISLAND MEDICAL JOURNAL.

The meeting adjourned at 10:00 p.m.

Attendance was 92.

Collation was served.

Respectfully submitted,

MICHAEL DIMAIO, M.D., *Secretary*

VIDEOTHERAPY AS AN OFFICE PROCEDURE

continued from page 255

suffered in childhood from overdependence on his mother and sister, later transferred to his wife. Discussion with his doctor increases his insight into his own behavior and he is then able to make a good start in standing on his own feet."

Other films of value in explaining mental mechanisms are: *Feeling of Rejection, Feeling of Hostility*, et cetera. As a matter of fact, our film library includes:

Johnny Learns His Manners
Preface To A Life
Children Growing Up With Other People
Problem Child
Feeling of Rejection
Feeling of Hostility
Overdependency
The Quiet One
Feeling of Depression
Emotional Health
The High Wall

Other films recommended are *Mental Mechanisms* and the *Inside Story*.

What Does Videotherapy Accomplish?

1. It is applicable in the treatment of the conduct disorders and functional disturbances.
2. It accomplishes abreaction which is, a release of tension, a loosening of defenses, and in particular with the proper interpretations, has therapeutic value.
3. It is also effective in that affect and pent up emotions are dissociated from other factors, and brought to the surface.
4. It accomplishes socialization and exteriorization of interests and provides hints and opportunities toward acquisition of new hobbies and healthier outlets, et cetera.
5. It permits spontaneous information to be elicited freely.
6. In treating children, it assists parents to gain insight and to develop patience and understanding which in turn enables them to modify their attitudes and thus to exert healthy and ennobling influences over their problem children.
7. It is a means of getting parents to share in the responsibility of the treatment program.

Experiences with Videotherapy

Specific aids in preparation for videotherapy: after a complete history is taken and preliminary examinations and studies have been done, the patient is told:

1. The doctor must know you better in order to help treat your condition. This is encouraged by requesting that the patient participate in the following:

a. to write an autobiography.
b. encouraging occupational therapy (this is done at home and creations are brought in and placed on an exhibit stand in the doctor's office where other patients can see them).
c. consulting pin-up board (a bulletin board to which the patient's attention is called. The patient's attention is called to helpful suggestions as to where to go, what to do, and what others are doing.)
d. bringing in pictures and articles of interest.
e. attending group discussions.

2. The patient is told he must know himself better to feel well and this is accomplished through:
a. psychotherapy
b. self-analysis
c. group therapy
d. lending library (bibliotherapy)
e. videotherapy

For videotherapy and group therapy the basic preparation is essential, for without the above introduction and ground work having been prepared, the results may be ineffective.

One of my patients, an elderly school teacher who already was experiencing an emotional upheaval and who at the time of the showing was tense, anxious and hostile became very indignant at the therapist because of the exteriorization of her own conflicts, and the implications which she attributed to the film. Her hostility was revealed in her criticisms.

The films may be shown individually or to groups. After a group or private showing, private sessions are held for the discussion of personal material. Hostility, projection, and other feelings are interpreted.

I believe the virtues and value of videotherapy should be extolled because of the possible adjunct to psychotherapy in private practice, in educational centers and in hospitals. In general, the psychiatric use of videotherapy has infinite possibilities and profound ameliorating influences may result—for example, in exteriorizing conflicts, in encouraging socialization of interests, discussion of conflicts, mental catharsis, re-education, re-assurance, and diagnosis.

A Typical Comment by a Patient

Gratifying results have been obtained through the use of videotherapy as evidenced by the following letter:

"Dear Dr. Mongillo: Was it Confucius who said, 'One picture is worth a thousand words'? If this is so, a series of pictures should be worth volumes. And if the pictures were put on film and shown as 'movies' they could be worth their weight in gold to some people, because of the help derived from viewing them.

continued on next page

"Educational moving pictures, especially those depicting health problems, both physical and mental, are of incomparable value, many times, in treating patients who have similar problems to solve and to whom words, alone, do not make as concrete a picture in the mind.

"After seeing some of these films in your office, it is my opinion that the intelligent use of these pictures should be used more and more by discriminating leaders in the medical field to help promote proper mental hygiene. The Industry would thus be encouraged to produce more and better pictures for their use and the benefits would be transferred to the thousands of human beings whose emotions prevent them from seeing themselves and their problems objectively.

"It is a pleasure to know that you are making use of these moving pictures and other progressive methods in your treatment of patients, and I feel sure that your humanitarian impulses will bring you much success in your work and a great deal of satisfaction.

"With my very best wishes for your continued ability to make your pictures worth a thousand words, I am Sincerely yours, L.D.F."

SUMMARY

1. Videotherapy can be used in psychiatric treatment, education in schools, mental hygiene programs, social service work, religious teaching, and marriage counseling.
2. Direct observation in a live medium when the patient is frequently unaware.
3. Rapport established easily and rapidly.
4. Diagnostic observations can be made.
5. Reactions of empathy, sympathy, re-identification, etc., can be observed.
6. Producers and psychiatrists should avail themselves of psychiatric advice and opinions in the use and preparation of films to be used for educational purposes or psychiatric treatment.

Conclusion

The above is a diagnostic, dynamic, synthetic and therapeutic approach, so that the child and the family relationships are studied and treated, eventually it is hoped, tending to alleviate parental anxieties and to promote the improvement of gross personality disorders in children and adults.

Videotherapy is a valuable adjunct to psychotherapy.

CHECK THE DATE . . .

***OCTOBER 14*—Cancer Conference**

For Rhode Island Physicians